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3/6/2009 –v-2

State Testimony

Testimony Before the California Senate Business, Professions & Economic Development Committee. Monday March 9, 2009

Thank you for the opportunity to testify. I am testifying on behalf of myself and Dr. Frank Sebat, an intensive care physician who practices in several northern Central Valley hospitals. We represent no organization. We have no conflicts of interest to report.

Peer review is designed to protect patients and improve the quality of a physician's care. Peer review is required by both California and federal regulations. Under peer review, a physician who is suspected to have committed an error is subjected to a review of his or her medical care by a jury of other physicians trained in the same specialty. The jury members are called "peers", hence the term "peer review". The process is administered by the medical staff and overseen by the board of directors of the hospital. When contested, an appeal is made which may involve a hearing officer, who is selected by the parties in conflict, and typically paid by the hospital.

Today I will provide evidence that the peer review process is broken and propose solutions.

Peer review is dysfunctional in two ways. First, when required, it is not done effectively or at all. We show this in our report: How Peer Review Failed at Redding Medical Center, Why It Is Failing Across the Country, and What Can Be Done About It. Our report was released to Congress on June 1, 2008. We found that peer review was not done at RMC in the cardiac services departments until 2003 and then was ineffective. Our analysis of reports from other hospitals, including personal reports to me, and the data held in National Practitioner Data Bank suggests that effective peer review is not performed at many other hospitals, permitting patient abuse and medical waste. Peer review may be ineffective or avoided motivated by conflicts of interest, which often are financial.

Our State agency is responsible to enforce our statute that requires peer review. The agency is the Licensing and Certification Division of the Department of Health and Human Services, called L&C. Our report shows L&C and CMS are **unable** to require hospitals to perform peer review. **The legislature must provide L&C with the tools it needs to enforce our laws.**

Our second finding, not contained in our RMC report, is that when peer review is performed, the process may violate requirements for due process guaranteed under law. When due process rights are violated, a hospital and its medical staff may unfairly suspend a physician's hospital privileges. We call this "sham peer review." This starts a cascade of events that eventually can ruin a physician's career. Several physicians who are victims of sham peer review have shared their detailed stories with me. A young competent surgeon whose career has been severely impaired by sham peer review has told you his story in writing. Our findings show that due process cannot be guaranteed when it is performed on a local level. Although we suspect ineffective peer review is far more common than sham peer review, peer review without due process is unacceptable.

So we have two problems with peer review:
One, it is ineffective or not done when required and,
Two, it can be subverted into a weapon to unjustly destroy the career of a competent physician.

To guarantee peer review is performed effectively as required, we need the following changes in law:

1. The legislature must provide to L&C appropriate **intermediate penalties** that it may levy against the medical staff and hospital for failure to conduct peer review. The intermediate penalty we recommend is to **withhold licensure** of a **specific** hospital **department** or section that has violated the peer review requirement **and** when it fails to take corrective action upon State resurvey. By withholding the license for specific services, the medical staff and hospital may not perform elective services until the peer review deficiency is corrected to L&C's satisfaction. For example, if our proposal was in law in 1999, L&C would have forced RMC to stop all its elective cardiac procedures and operations until the required peer review was performed in those hospital departments. The required peer review would have detected the substandard care and would have saved hundreds of heart patients from abuse between 1999 and 2002. Timely detection of substandard care may have prevented RMC from being kicked out of the Medicare Program, which happened in 2003. Timely peer review may have saved the careers of the two talented but negligent doctors who no longer practice medicine. One of these doctors trained to be a cardiac surgeon for at least 13 years after high school graduation. Think of the medical care resource we all lost. Reportedly he was an excellent surgeon who did not benefit from peer guidance when he needed it.

2. When L&C must discipline a department of a hospital for violation of our peer review requirements, L&C should be instructed to report the matter to major insurance companies and government contractors who pay claims to that hospital and relevant medical staff members. This will allow the insurers to focus their auditing resources on the claims and medical records of these providers in order to discover waste, abuse, and fraud. Our finding at RMC demonstrates that peer review may be blocked in order to make money from unnecessary services. A red flag for ineffective peer review may be over or under-utilization of services.

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Now I will address the second problem by proposing a method to assure due process within peer review.

To assure proper administration of justice, a party to the proceeding, in his or her sole discretion should be granted the right to access a regionally based peer review process. When no party objects, the process may remain within a local community and governed by the by-laws of the medical staff. But when any party objects, the process must be performed through a regional process. The regional peer review system we propose will stimulate local peer review to become effective and provide due process.

We recommend we create the following structure for regional peer review:

1. The process must be overseen by a state agency, such as L&C.
2. The process shall be funded by user taxes and fees.
3. The Agency must develop a pool of hearing officers to administer a hearing when required, much as an administrative law judge is made available to administer a labor law dispute.
4. The Agency shall develop a pool of qualified medical experts, proposed by medical societies and other appropriate groups, who agree to serve as a "jury of peers." These experts shall rule on the medical matters in controversy.
5. When a case comes up, these experts shall be selected by the Agency.
6. The experts must be without bias and drawn from outside the community in which the reviewed physician practices.
7. Physicians and other stakeholders from the local medical staff and hospital, and other qualified experts, may provide testimony at the hearing, under a due process requirement assured by the hearing officer, but shall not determine the outcome.
8. The law shall provide due process rights for all concerned. For example, a *voir dire* process shall be permitted, and the hearing officer may not dismiss the hearing.

In closing, we find that peer review can be abused so that competent physicians may be excluded from their profession without a right to due process. More commonly, we also find incompetent physicians are hidden when peer review is ineffective or not done, resulting in harm to patients.

We present a total of 17 recommendations in our RMC Disaster analysis. I have emphasized some today. We hope local peer review will become effective and just, though enforcement of current requirements. Without proper administrative enforcement, a disaster like the one at Redding Medical Center will happen over and over again.

Thank you for the opportunity to share our findings and proposed solutions.
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